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EDITORIAL

If One Drug Is Good, Then Two Drugs Are Better?

"If TWO DRUGS, A and B, are administered together, then the net pharmacologic effects may be the same, less than, or more than if A and B had been administered separately." Such a statement accompanied by terms such as antagonism (clear) and potentiation (fuzzy), introduces the subject of drug interaction to students in pharmacology courses. Ordinarily little time is devoted to interactions *per se* and the descriptive pharmacology of single agents occupies the major portion of the instructor's time. However, even superficial perusal of the scientific literature reveals that drug interactions in man are all too common, often with serious consequences. The patient, and especially the in-patient, has become the "laboratory animal" in which most drug interactions have been studied — unfortunately in a retrospective manner. Clearly, this subject must be brought to the attention of all those who have responsibility for drug therapy. Elsewhere in this issue of CALIFORNIA MEDICINE [page 380] Morrelli and Melmon have reviewed much of the literature concerning drug interactions. They stress the importance of knowing the mechanisms of drug action and the variables that influence pharmacologic activity as necessary prerequisites to the understanding of how drugs interact.

The examples of interaction in this review are often those which involve a shift in the dose-response curve of one drug caused by some action of another drug. Since such shifts can and do occur in both directions, it is immediately obvious that in cases where several drugs are administered to one patient the doses of all drugs may have to be adjusted to achieve the maximum therapeutic effect with a minimum of toxicity. Optimal individualization of dosage requires careful observation, calling into question the indiscriminate use of fixed-dose combinations in which two or more drugs are compounded in the same tablet or capsule.

Polypharmacy is a fact. Whether or not patients receiving multiple drug therapy suffer or benefit depends upon the physician's awareness that interactions can occur, his understanding of the pharmacologic properties of the drugs he prescribes, and the availability of up to date information concerning drug interactions in man. Timely review articles such as the one by Morrelli and Melmon in this issue should be of great value to the physician who needs to keep abreast of this rapidly expanding area of drug therapy.

Rising Health Care Costs

HEALTH CARE COSTS are rising. Quite properly this is being viewed with concern, and sometimes alarm, by government, labor and the public who of course must ultimately pay these costs. Physicians, hospital administrators and others in the health care industry are also and properly disturbed. As

might be expected, there is a natural tendency to blame this unpopular state of affairs on someone or something which can be made a scapegoat. There have been allegations and accusations against money-mad physicians, uneconomic hospital practices, inefficient health care delivery systems, unnecessary and excessive union wage increases, and unreasonable demands and expectations on the part of government or the public. A convenient catch-all is inflation, to which almost everyone gives some of the blame. But no one of these scapegoats, nor even all of them together, can account adequately for the rising health care costs. The true cause is far more basic and far less often given its due.

It is suggested that the major rise in health care costs can be traced back to a philosophy engendered by the very expensive but very successful Manhattan Project of World War II. This philosophy states that almost anything can be accomplished if one is willing to spend enough money to get it done. World War II promptly terminated when the atomic bomb became available and was used. The money spent on the Manhattan Project achieved its purpose. A scientific and technologic miracle had been accomplished.

The principle was next applied on a large scale in medical research with the expectation that if enough money were spent, scientific and technologic miracles could also be worked in this field—and this time for the betterment of mankind. Vast sums were contributed from both public and private sources, research thrived, and there were many impressive results. Progress in medical science was dramatic and it was also very well dramatized. The prospect of better health for all was clearly on the horizon for everyone to see and the public responded with rising expectations followed by increasing demands until health and health care are now generally accepted as human rights somehow to be guaranteed by society. But not yet settled is just how this is to be done, what the cost will be, or how it is to be paid for.

As might be expected the principle of the Manhattan Project is once again being applied in the hope that another scientific and technologic miracle can be achieved. Vast sums of money are being pumped into the health care system, again from both public and private sources. The government's focus has been particularly upon the removal of any significant financial barriers to the health care of the aged and the indigent of any age, and to

make sure that this care is rendered to all with equal dignity and within the mainstream of good medical practice. It may be expected that substantial funding will soon become available for manpower procurement and training, for better deployment of knowledge and skills, for equipment and facilities, and for planning regional and community health services. The non-governmental focus has been to develop better programs, quality standards and utilization control within the private sector. The emphasis has been upon accomplishing all this by strengthening the vital pluralistic system which has characterized health care in this nation and encouraging it to plan and experiment to find better and more efficient answers. This is as it should be.

It would seem then that the basic cause of the enormous rise in the amount of money being spent on health care is simply a national decision to spend more money to bring more sophisticated health services to many more people and to do this on a grand scale on the theory that almost anything can be accomplished if one is willing to spend enough money to do it. This does not say that such things as inflation, increases in wages, salaries, fees, cost of living and cost of working, supplies, equipment, facilities and operating overhead do not contribute to these rising costs. But it does suggest that allegations and accusations will do little to help, and that while improvements in economic efficiency and productivity must be sought and put to use, these will by no means be sufficient to control the rising costs of health care. As long as there is a national commitment to make a greater number of more sophisticated and expensive services available to a greater number of better informed and more demanding people, and as long as both the public and the private sector are willing to spend more and more to do this, the amount of money spent on health care will inevitably increase, and thus the costs will continue to rise by any measure and in spite of whatever rhetoric is used. It is time this basic fact is recognized and accepted for what it is by all concerned.

A Recognition Well Earned

THE NORMAN A. WELCH, M.D., Memorial Award was presented to the California Medical Association by the National Association of Blue Shield Plans in recognition of the "scholarly and merito-